DEPARTMENT OF HEALTH AND HUM' 'SERVICES
CENTERS FOR MEDICARE & MEDICA.D SERVICES

45th 4/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to notify the physician of a laboratory result requiring altering	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 157 It is the practice of this facility to ensure that the resident, physician, and/or the legal representative is consulted when an accident occurs involving an injury, significant change of status, a need to alter treatment significantly, or a decision to transfer or discharge the resident from the facility as specified. Resident # 6 was re-assessed and continued monitoring to ensure no adverse effects as a result of laboratory results not being reported to the physician in a timely manner. Residents who have had abnormal laboratory tests resulted beginning February 1, 2011 through March 16, 2011, have been reviewed to assure that timely physician notification has occurred and appropriate physician orders/interventions were received. Licensed nursing personnel will be educated on the requirement of timely notification to the physician on all laboratory test results. This education will to be done by the Staff Development Coordinator (SDC), or the Director of Nursing Services (DNS) or designee on March 7, 8,9,15,18,21,22, and 25 if necessary. Each weekday morning the unit manager/ADNS/DNS or designee will follow up on laboratory tests that have been ordered to ensure specimens have been drawn / obtained and sent to lab, results are returned to facility timely, physician notified timely orders obtained as indicated and appropriate medical record documentation is in place. DNS/ ADNS / Unit manger will report results in the manager's weekday morning meeting to assure compliance.	April 11, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

B. Scott Hunt — Ex. Director — 3/17/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MAR 17 2011

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F 157	Continued From page 1 treatment for one (#6) resident of twenty-six residents reviewed. The findings included: Resident #6 was admitted to the facility on August 24, 2006, with diagnoses to include Hematochezia with Gastrointestinal Hemorrhage, Hypertension, and Osteoporosis. Observation on March 1, 2011, at 1:00 p.m., revealed resident #6 was asleep in bed and watched over by two nieces. Medical record review of the Physician Telephone Order dated February 22, 2011, revealed an order for Urinalysis with Reflex (first step to culture and sensitivity). Medical record review of the Physician Telephone Order dated February 23, 2011, revealed an order for the antibiotic Cipro 500 milligrams to be administered twice a day for seven days. Medical record review revealed the results of the culture and sensitivity were reported to the facility on February 25, 2011. The report identified the antibiotic Cipro was not effective against the specific pathogen present in the urine sample of resident #6. Medical record review of the Physician Telephone Order dated February 28, 2011, (three days later) revealed an order to stop the antibiotic Cipro and to administer the antibiotic Rocephin intramuscularly. Interview with the Director of Nursing Services	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The process will be reviewed by the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities, and Medical Director) at least quarterly, for review and recommendations as indicated.	

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F 157	Continued From page 2 (DON) in the DON's office on March 3, 2011, at 10:50 a.m., verified the facility had the results of the culture and sensitivity for three days before notifying the physician, thus failing to notify the physician timely of the laboratory results.	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a comfortable and homelike environment for one resident (#13) of twenty-six residents reviewed. The findings included: Resident #13 was admitted to the facility on April 2, 2008, with diagnoses including Colon Cancer, Hypertension, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, and Cirrhosis. Observation on March 1, 2011, at 10:25 a.m., in the resident's room revealed the resident awake, lying on the bed. The wall behind the bed had an area approximately three feet wide and four feet tall with the wallpaper removed and brown wallboard visible. The remainder of the wall was a pale green color. Interview with the resident on March 1, 2011, at 10:25 a.m., revealed when asked what had	F 252	F 252 It is the practice of this facility to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. On March 1, 2011 Resident # 13 was temporarily transferred from her room and maintenance personnel repaired the wall and painted the room. On March 4 2011, the maintenance supervisor inspected each room making sure all rooms meet the resident's needs. A list has been obtained to assure proper maintenance of all rooms. The supervisor will report any changes to the rooms in the morning stand up meeting. The Administrator and maintenance supervisor have incorporated a plan /schedule into the facility PM program to repair and maintain resident rooms in a safe, homelike and comfortable environment. The supervisor will monitor on rounds at least 3 days a week and report any issues/changes to the rooms in the weekday morning stand up meeting. The maintenance supervisor will report to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities Director, Case Mgr, and Medical Director) at least quarterly, for review of any resident's request for painting or repair to maintain a safe, homelike environment.	April 11, 2011

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F 252	Continued From page 3 happened to the wall, resident replied "...They had to take the wallpaper down behind the bed to fix something. They said they would fix it but they haven't. I have talked to...(Director of Plant Operations and Maintenance Assistant #1) but they haven't done anything. It's been about a year, I wish they would fix it, my daughter covered it at Christmas but the rest of the time it looks like this, it bothers me..." Interview with the Director of Plant Operations and Maintenance Assistant #1 on March 1, 2011, at 10:50 a.m., in the conference room, revealed they were both aware of the disrepair of the resident's wall. Maintenance Assistant #1 confirmed "...the wallpaper was taken down because it was all torn up..." and that it had "probably been around a year since it had been removed. (Resident) would need to be out of the room while repairs are made, but we haven't talked to (resident)..." The Director of Plant Operations confirmed "...It just got away from us..." and Maintenance Assistant #1 added "...It hadn't come back around..." and agreed the wall was in disrepair and "...needs to be fixed..."	F 252		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 4 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to ensure staff washed the hands after removing gloves for one nurse (#1) of six nurses observed for medication administration. The findings included: Observation on the 200 hall on March 2, 2011, at 11:00 a.m., revealed Licensed Practical Nurse (LPN #1) gathered supplies to test a blood	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 441 It is the practice of this facility to provide and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment that prevents the development and transmission of disease or infection. LPN #1 has been educated on proper hand washing procedure when obtaining blood samples. The licensed nursing staff will be educated on Hand Hygiene/Hand washing procedures when obtaining blood samples to insure that the spread of infection is prevented. The SDC/DNS or designee will in-service LN staff on March 7, 8,9,15,18,21,22, and 25 if necessary. The DNS/ADNS/SDC/Unit Manager or designee will observe for competency of licensed nursing personnel to assure compliance with our policy and procedure at least twice a week on each unit each shift x one month, then weekly x one quarter and monthly thereafter. The DNS or designee will report to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities Director, Case Mgr, and Medical Director), at least quarterly, analysis of infections, trends and interventions as indicated.	April 11, 2011

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F 441	Continued From page 5 glucose level and administer a medication to resident #26. Continued observation revealed LPN #1 donned gloves to both hands and entered the room of resident #26. Continued observation revealed the resident was administered the medication; the nurse wiped the resident's finger with an alcohol pad and obtained a blood sample on the test strip. Continued observation revealed LPN #1 entered the bathroom in the resident's room; removed the gloves; exited the room; and carried the test strip down the hallway to the medication cart which contained the glucose analysis machine. Continued observation revealed LPN #1 tested the strip and wrote down the blood glucose results before walking down the hall to wash the hands. Review of the facility policy titled, Hand Hygiene/Handwashing revealed..."Hand hygiene is to be performed: ...After touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves were worn..." Interview with LPN #1 at the medication cart on March 2, 2011, at 11:11 a.m., verified the hands were not washed after the gloves were removed after obtaining a blood sample. Interview with the Director of Nursing Services (DON) in the DON's office on March 2, 2011, at 12:15 p.m., confirmed the facility failed to follow hand washing protocol.	F 441		